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revisions were made and adequate supervision was provided for Residents #1, #4, #5, #6 and #7 related to their behaviors of grabbing food/drinks.

On 09/01/10, staff placed bread (regular consistency) at the table accessible to Resident #1. Staff did not provide supervision to ensure Resident #1 did not gain access to the bread despite having knowledge of this resident's history of attempts to obtain food of a different consistency. Staff observed Resident #1 with bread in his/her hand and removed it; however, the resident began to choke. Staff initiated the Heimlich Maneuver; however, this method was not successful. The resident stopped breathing and had no pulse. Emergency Medical Services had to insert a Laryngoscope (instrument inserted into the airway to provide visual access) into the resident's throat to remove the bread with forceps. The resident was sent out to the hospital.

The Administrator's failure to ensure adequate supervision was provided for residents' at risk for choking, represented a situation that had caused and was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/21/10 and found to exist on 09/01/10 and was ongoing. Substandard Quality of Care was identified at 483.25 Quality of Care. The facility was notified on 09/21/10.

The findings Include:

Based on observations, interviews and record reviews, it was determined the facility failed to revise the care plans for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. Interviews with staff revealed the residents had

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To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated on P&P for documentation requirements, via staff in-services. Information related to reporting of behaviors, adequate supervision and seating arrangements in dining were also included in staff in-services. In-services were conducted by the DNS, WS & UMs beginning on 9/17/10. Staff will not be allowed to work until attending all appropriate in-services.

The DNS, UMS and Weekend Supervisor initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10. In-service content included care plans and care plan meetings and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff was educated that activity seating groups will be assigned according to individual needs as assessed. The DO and DDCO initiated Investigative Training in-servicing on 09/18/10 with the ED and DNS. The DDCO completed in-servicing to all Administrative Staff (ED, DNS, CM,

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F 490	Continued From page 47 behaviors of grabbing food off of dining room tables and other residents' trays that was not the right consistency food for these residents. The residents' care plans were not revised to address the residents' behaviors of grabbing food/drinks and the need for adequate monitoring and supervision to prevent choking. Refer to F280 Based on observations, interviews and record reviews, it was determined the facility failed to provide adequate supervision to prevent accidents for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. The facility failed to supervise and monitor residents who required supervision due to choking risks while eating. Facility staff was aware of Residents' #1, #4, #5, #6 and #7 history of attempts to obtain food of a different consistency than their diets, but failed to develop and implement interventions to prevent the residents from obtaining the food/fluids. Refer to F323 Based on observations, interviews and record review, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented, with sufficient information regarding resident assessments related to problem behaviors and development and implementation of care plan interventions needed for adequate supervision for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. Additionally, the facility failed to follow its' established policy and procedures related to documentation of the information for each resident. Refer to F514. A review of the facility's Accidents and Supervision to Prevent Accidents policy and	F 490	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* MDSC, Social Worker, UM, RD, Activity Director, Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Reports and Investigative Protocol. The DNS and UM initiated additional in-servicing on 09/21/10 with all direct care staff to include licensed nurses, SRNAs, and Activities staff related to meal supervision. In-services will continue until all appropriate staff have attended the appropriate in-service. Staff will not be allowed to work until having attended the appropriate in-service. The ED and DNS will be responsible to validate that staff do not work prior to receiving the in-service. The in-service will be included in New Employee Orientation for all new hires. The facility does not utilize Agency Staff. If the facility should employ Agency Staff, they will receive the in-service prior to working. The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine need for additional action steps. If no	

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procedure, dated 08/06/07, revealed the center provided supervision to each resident to prevent avoidable accidents. This included systems to identify and evaluate hazards and risks, implement interventions to reduce hazards and risks and to monitor the effectiveness and modify approaches when necessary. The center identified hazards and the risks of the resident having an unavoidable accident through Quality Assurance activities, medical history, physical exam and individual observation. Staff was involved in observing and identifying potential hazards. The Center investigated accidents and developed a plan of action to prevent the accident from reoccurring. A review of the Accidents and Supervision to Prevent Accidents Definitions revealed an avoidable accident was when the facility failed to identify: 1. environmental hazards and individual resident risk of an accident, including supervision, 2. evaluate the hazards and risks and 3. implement interventions, including adequate supervision, consistent with the resident's needs, resident's goals, resident's plan of care, and current standards of practice in order to reduce the risk of an accident. Lack of Supervision was the lack of adequate supervision to prevent accidents occurred when the center failed to accurately assess a resident to determine whether supervision to avoid an accident or injury was necessary. Refer to F323

An interview with the Administrator, on 09/21/10 at 10:45 AM, revealed she made rounds every morning, talked to residents, reviewed 24 hour reports, monitored staff answering call lights, talked with staff and come in on different shifts to try to ensure staff were providing adequate supervision for the residents. She stated she participated in daily stand-up meetings and

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concerns are identified during the weekly (Tuesday) PIC meetings, the audits will take place on a monthly basis for two months and on an as needed basis thereafter. The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated. The Interdisciplinary Team, to include but not limited to, (ED, DNS, UM, RD, Social Worker, DM, Activities Director, will review all resident events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected residents, other facility residents with the potential to be affected, to identify the need for systemic changes and to validate that the PI process is effective.

The ED is responsible for overall compliance through attendance at the Stand -Up Meetings and by reviewing audits to ensure they were conducted. The ED will assume overall responsibility for the Performance Improvement Program at the Facility. The ED will utilize weekly (Wednesday) IDT

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F 490	Continued From page 49 Quality Assurance activities. She revealed she was not aware Residents #1, #4, #5, #6 and #7 had behaviors of grabbing other residents' food/drinks and that the information was not documented in each resident's clinical record. A credible allegation of correction for removal of the Immediate Jeopardy was received on 09/22/10. The Immediate Jeopardy was verified removed on 09/22/10, prior to exit. The alleged date of removal was 09/22/10. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 09/22/10. The AOC revealed: Affected residents: On 09/02/10, the ARNP communicated to all direct care staff, licensed nurses, State Registered Nurse Aides, that Resident #1 would be seated in the dining room at a table with other residents who received the same type of mechanically altered diet. On 09/07/10, the care plan was updated to reflect dining room seating arrangements for Resident #1. On 09/16/10, the care plan was updated to reflect a problem of At risk for Choking Possible Aspiration related to Dementia with Impulsive Behavior , Past Behavior of Grabbing food and/or liquids, with interventions to include but not limited to: provide LCS pureed diet with honey thick liquids by small spoon per staff; encourage po intake and po fluids, fed per staff; encourage dining room attendance each meal and sit with residents with same texture diet; supervise all po intake and meal times. On 09/21/10, the care	F 490	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.	Completion date 9/23/10

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plan was updated, with a problem of no safety awareness as the resident grabs out for people and items, with interventions to include but not limited to: keep the resident in a supervised area when out of the bed; notify the nurse of any abnormal behavior. be attentive to the resident when reaching; and encourage the resident to attend activities.

In addition, the Executive Director (ED), Director of Nursing Services (DNS), the District Director of Operations (DO), and the District Director of Clinical Operations, (DDCO), conducted further investigation for Resident #1 on 09/19/10. This investigation consisted of staff interviews and medical record reviews, to include but not limited to: the comprehensive Minimum Data Set (MDS) Assessments, Resident Assessment Protocols (RAPs), Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes. The 24-hour report, the Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. The SRNA Assignment Sheets and the Dining Room Seating Arrangement Diagram were updated for Resident #1.

The care plan for Resident #4 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing at items on dining room tables, including food, with interventions to include but not limited to: place at a table with residents with same diet; tablecloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify the nurse of

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F 490	Continued From page 51 any new abnormal behaviors. The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include but not limited to: seat at table with others who have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify the nurse of any new abnormal behaviors. The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but in past, had taken food from others rooms or trays and over eating, with interventions to include but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow down if eating fast; notify nurse of any new onset of abnormal behaviors and document. The care plan for Resident #7 was revised on 09/16/10 with a problem of Socially Inappropriate Behaviors, at time unable to tell the difference from edible and non-edible item, history of taking food off others' trays, with interventions to include but not limited to: place at table without centerpieces; staff to monitor during meals; will not be seated within reach of other residents' food at meals. Homemade bread will continue to be served during meal service as appropriate and in accordance with MD order for diet consistency. For residents with mechanically altered diets,	F 490		

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bread will be altered accordingly and served with the meal service.

Effective 09/17/10, residents who have known behaviors of reaching for and obtaining items that are not on their meal trays or that are inedible, have been arranged to be seated at tables with residents with the same MD ordered mechanically altered diet. This is reflected on the Dining Room Seating Assignment Chart, effective 09/17/10.

Effective 09/02/10, each meal service is monitored by a licensed nurse for the duration of the meal service. SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to conduct observations of all residents during the meal service to identify behaviors or concerns. The licensed nurse is responsible to document any behaviors or identified concerns on the Meal Supervision Log, the 24-hour report and to report the behaviors or identified concerns to the Director of Nursing Services and/or the Social Worker. The DNS and CM will also review the Meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed on the care plans and that supervision is appropriate. On addition, the DNS and CM participate in the licensed staff dining room observations to validate appropriate supervision.

Effective 09/17/10, each activity with meal service is monitored by the Activities Staff for the duration of the meal service. Activities Staff are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to document any behaviors

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or identified concerns on the 24-hour Report and to report the behaviors or identified concerns to the DNS and/or Social Worker(SW).

Effective 09/17/10, Administrative Licensed Nurses (DNS), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Minimum Data Set Coordinator (MDSC), Case Manager (CM), Weekend Supervisor (WS) and Staff Development Coordinator (SDC), participate in the licensed staff dining room observations. Administrative nurses through direct observations will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Reports and report to the DNS and SW.

Meal Supervision, behaviors and/or concerns will be documented at each meal on the Meal Supervision Logs. The Meal Supervision Logs will be reviewed daily in the Stand-Up meeting and on weekends by the WS to identify any concerns and to validate that appropriate corrective actions have been taken. Any concerns identified will be documented on the Meal Supervision Logs at the time of the review.

All direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food, and to document on the 24-Hour Reports and to address in care plans.

Other Facility Residents with the Potential to be Affected:

The DNS, UM, Registered Dietician (RD) and Assistant Dietary Services Manager (ADSM) reviewed the medical records of all other facility residents on mechanically altered diets on

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F 490	Continued From page 54 09/19/10. Record reviews included but were not limited to: the comprehensive MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs, and Resident Progress Notes. The 24-Hour Report, The Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. Record reviews were conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The Comprehensive Care Plans, the State Registered Nurse Aide Assignment Sheets and the Dining Room Seating Arrangement Diagram were updated as indicated, based on record reviews and staff interviews. To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated to document on the 24-Hour Reports, the Resident Progress Notes and on the Behavior Logs and to address on the care plans. The SRNAs were educated to document on the Behavior Logs and report to the licensed nurse. The DNS and CM will conduct 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plans. The DNS, UM, MDSC, Case Manager (CM), and Advanced Register Nurse Practitioner (ARNP)	F 490		

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reviewed the medical records of all facility residents on 09/21/10. Record reviews included but no limited to: the MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes for the previous 30-day period. Record reviews were conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The comprehensive care plans, SRNA Assignment Sheets and Dining Room Seating Arrangement Diagram were updated, as indicated, based on record reviews and staff interviews.

In addition, on 09/21/10, all SRNA Assignment Sheets were updated to reflect the intervention for staff for report any and all new behaviors to the licensed nurse.

Systemic Changes to Prevent Reoccurrence of Deficient Practice:

The DNS, UMS and Weekend Supervisor initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10. In-service content included care plans and care plan meetings and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff were educated that activity seating groups will be the same as the Dining Room Seating Assignment Chart.

The DO and DDCO initiated Investigative Training in-servicing on 09/18/10 with the ED and DNS. The DDCO completed in-servicing to all

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Administrative Staff (ED, DNS, CM, MDSC, Social Worker, UM, RD, Activity Director, Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Reports and Investigative Protocol.

The DNS and UM initiated additional in-servicing on 09/21/10 with all direct care staff to include licensed nurses, SRNAs, and Activities staff related to meal supervision.

In-servicing was initiated on 09/17/10 and 09/20/10 and will continue until all appropriate staff have attended the appropriate in-service. Staff will not be allowed to work until having attended the appropriate in-service. The in-service will be included in New Employee Orientation for all new hires. The facility does not utilize Agency Staff. If the facility should employ Agency Staff, they will receive the in-service prior to working.

The ED and DNS will be responsible to validate that staff do not work prior to receiving the in-service. A sign is posted at the time clock to notify staff they are not to work or provide care to any resident prior to reporting to a charge nurse to receive the in-service. If the staff in need of in-service is a charge nurse, they are to report to a charge nurse on a different unit.

Facility Monitoring:

An ad hoc Performance Improvement Committee was held on 09/17/10. Members in attendance

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F 490	Continued From page 57 included the ED, DNS, UM and RD. The Medical Director was notified of the Facility Action Plan on 09/20/10. The ED, DNS, RD and WS will audit residents on mechanically altered diets through staff interviews, direct observations of dining services and through record reviews of Behavior and Mood Logs and Resident Progress Notes. The reviews will also include the Meal Supervision Logs and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audits will validate that all behaviors have been appropriately identified and addressed. The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behavior have been appropriately addressed on the comprehensive care plans. The audits will include but not be limited to: the MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes for the previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observations. In addition, the audits will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plans.	F 490		

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The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine need for additional action steps.

If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits will take place on a monthly basis for two months, and on an as needed basis thereafter.

The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated.

The Interdisciplinary Team, to include but not limited to, (ED, DNS, UM, RD, Social Worker, DM, Activities Director, will review all resident events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to validate that the PI process is effective.

The ED is responsible for overall compliance through attendance at the Stand -Up Meetings and by reviewing audits to ensure they were conducted. The ED will assume overall

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responsibility for the Performance Improvement Program at the Facility.

The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.

In addition, the DDCO will conduct weekly calls with the facility to review events from the previous week to validate that all events are thoroughly investigated, to include care plan revisions.

Interviews conducted on 09/22/10, during the extended survey, with the DON and direct care staff (Social Worker #2, RN #1, RN #3, LPN #2, LPN #6, LPN #7, LPN #8, CNA #3, CNA #5, CNA #6, CNA #11, CNA #13, CNA #14 and CNA #15), revealed there was now seating chart for the dining room. Residents were seated with residents on the same diet consistency. Licensed staff were present in the dining room for all meals and Administrative staff participated in the dining room services. They revealed if any behaviors were noted, the staff reported the behavior to the licensed staff in the dining room. The licensed staff then documented them on the behavior logs in the dining room and reported them to the charge nurse and documented them on the 24 hour reports and in the residents' records.

Observation of the noon meal, on 09/22/10, revealed Resident #1 was seated at a table by him/herself. No food was placed on the table until

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F 490	Continued From page 60 Resident #1's tray was served. The CNA immediately sat down next to the resident when the tray was served. Residents #4, #5, #6 and #7 were seated with residents with like diets and were seated according to the dining room seating chart. A licensed staff was present during the entire meal. Staff were reporting observations of behaviors to the licensed staff during the meal. A review of the Dining Room behavior observation sheet for 09/22/10 revealed each resident's name was documented with the behaviors that was observed. Observations of Resident #1 on 09/22/10 (throughout the day) revealed the resident was in a wheelchair sitting in the area across from the nurse's station, in view of staff. A review of Residents' #1, #4, #5, #6 and #7 comprehensive care plan revisions, revealed the care plans had been revised to include individualized interventions for each resident, to include supervision, related to the residents' behaviors of grabbing food/drinks. Reviews of the in-service training provided to all direct care staff, dated 09/17/10, 09/18/10, 09/19/10 and 09/21/10, revealed all staff received training on care plans and care plan meetings, assigned seating charts, dining/meal service supervision, activity seating groups, to report any and all behaviors (to include wandering or reaching for objects to include food/drink) and documentation. In addition, Administrative Staff were in-serviced on Documentation, Documenting the Residents' Health Status, Needs and Services, Documenting in a Resident's Medical Record and on the 24- Hour Reports on 09/20/10. The Executive Director and DON received in-servicing on 09/18/10 related to conducting investigations.	F 490		

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F 490	Continued From page 61 Although it was determined the Immediate Jeopardy was removed on 09/22/10, non-compliance continued with the scope and severity of a "D", based on the facility's need to monitor for the on-going effectiveness of the corrective actions taken and to ensure evaluation through the facility's Quality Assurance process.	F 490	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 514 SS=K	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented, with sufficient information regarding resident assessments related to problem behaviors and development and implementation of care plan interventions needed for adequate supervision for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. Additionally, the facility	F 514	F 514 On 09/07/10, the care plan was updated to reflect dining room seating arrangements for Resident #1. On 09/16/10, the care plan was updated to reflect a problem of At risk for Choking Possible Aspiration related to Dementia with Impulsive Behavior , Past Behavior of Grabbing food and/or liquids, with interventions to include but not limited to: provide LCS pureed diet with honey thick liquids by small spoon per staff; encourage po intake and po fluids, fed per staff; encourage dining room attendance each meal and sit with residents with same texture diet; supervise all po intake and meal times. On 09/21/10, the care plan was updated, with a problem of no safety awareness as the resident grabs out for people and items, with interventions to include but not limited to: keep the resident in a supervised area when out of the bed; notify the nurse of any abnormal behavior, be attentive to the resident when reaching; and encourage the resident to attend activities. The care plan for Resident #4 was revised on 09/17/10 with a problem of Inappropriate	

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F 514	Continued From page 62 failed to follow its' established policy and procedures related to documentation of the information for each resident. Staff interviews and record review revealed Resident #1 was identified by the facility as at risk for choking and received a specialized diet consistency. However, the facility staff was aware Resident #1 had exhibited behaviors of grabbing food and fluids from other residents or from the dining table, which was not the consistency ordered for the resident. There was no evidence the known behaviors had been documented or included in the resident's care plan with interventions developed and implemented to ensure Resident #1 was adequately supervised during eating. On 09/01/10, Resident #1 choked on bread the resident obtained from a plate placed on the table by staff. The resident stopped breathing and had no pulse. Staff were unable to revive the resident at the facility and Emergency Medical Services responded and had to insert a Laryngoscope (instrument inserted into the resident's airway to remove the bread with forceps.) The resident was transported to the hospital. Interviews and record reviews revealed after the incident, the facility failed to correct the lack of documentation of behaviors for Residents #1, #4, #5, #6 and #7. The facility's failure to maintain clinical records that were complete and accurate for residents at risk for choking, represented a situation that had caused and was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/21/10	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Behaviors of grabbing at items on dining room tables, including food, with interventions to include but not limited to: place at a table with residents with same diet; tablecloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify the nurse of any new abnormal behaviors. The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include but not limited to: seat at table with others who have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify the nurse of any new abnormal behaviors. The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but in past, had taken food from others rooms or trays and over eating, with interventions to include but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow	

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and was found to exist on 09/01/10 and was on-going. Substandard Quality of Care was identified at 483.25 Quality of Care. The facility was notified on 09/21/10. Findings include:

A review of the facility's policy and procedure for Documenting in a Resident's Medical Record, dated 10/31/09, revealed the medical record should serve as a planning tool for resident care, to record the course of the resident's treatment and changes in medical condition and to document communication between the healthcare members.

1. Record review revealed Resident #1 was admitted to the facility with diagnoses to include Dementia, Diabetes Mellitis and Cerebral Vascular Accident.

Interviews with the Activity Director on 09/17/10 at 3:50 PM, Registered Nurse (RN) #1 on 09/17/10 at 2:40 PM, RN #2 on 09/16/10 at 2:40 PM, Licensed Practical Nurse (LPN) #1 on 09/16/10 at 5:20 PM, LPN #2 on 09/17/10 at 1:40 PM, LPN #3 on 09/20/10 at 10:55 AM, LPN #4 on 09/17/10 at 3:00 PM, Certified Nurse Aide (CNA) #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM, CNA #8 on 09/16/10 at 5:50 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 had behaviors of grabbing food and/or fluids off of residents' trays and from the dining room table prior to 09/01/10. The staff stated they immediately took the food/fluid away from the resident. The staff revealed they tried to keep an eye on the resident because of the

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down if eating fast; sit out of arms reach of other trays; notify nurse of any new onset of abnormal behaviors and document. The care plan for Resident #7 was revised on 09/16/10 with a problem of Socially Inappropriate Behaviors, at time unable to tell the difference from edible and non-edible item, history of taking food off others' trays, with interventions to include but not limited to: place at table without centerpieces; staff to monitor during meals; will not be seated within reach of other residents' food at meals.

The DNS, UM, Registered Dietician (RD) and Assistant Dietary Services Manager (ADSM) reviewed the medical records of all other facility residents on mechanically altered diets on 09/19/10. Record reviews included but were not limited to: the comprehensive MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs, and Resident Progress Notes. The 24-Hour Report, The Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. Record reviews were conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The Comprehensive Care Plans,

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resident's behaviors of grabbing food and drinks from tables and other residents' trays. They stated everyone was aware that Resident #1 had this behavior because the resident did it all the time. However, review of the Comprehensive Care Plan revealed there was no revision to the care plan to address the resident's behavior of grabbing other resident's food off the trays or from the table.

Interviews on 09/17/10 at 3:00 PM and on 09/20/10 at 10:50 AM, with the Minimum Data Set (MDS) Supervisor, RN Supervisor and Social Worker #1 (who participated in the resident's care plan meetings), revealed they were not aware Resident #1 had behaviors of grabbing food from the table and other residents' trays. They stated the behavior should have been documented in the record or brought up by staff in the care plan meeting so the behavior could have been addressed in the resident's care plan.

Interviews with RN #3 on 09/17/10 at 10:40 AM, LPN #5 on 09/17/10 at 10:20 AM, LPN #6 on 09/16/10 at 3:40 PM, CNA #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 was seated at a table on the third row in the dining room with other residents for the noon meal on 09/01/10. The staff had placed sliced fresh baked bread on saucers and passed it out to the residents who were on regular diets. The staff revealed they started passing out trays to the residents at the first row of tables. CNA #9 revealed as she turned around to pass a tray, she observed Resident #1 with a slice of bread in his/her hand. CNA #9 stated Resident #1 had

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the State Registered Nurse Aide Assignment Sheets and the Dining Room Seating Arrangement Diagram were updated as indicated, based on record reviews and staff interviews. In addition, on 09/21/10, all SRNA Assignment Sheets were updated to reflect the intervention for staff for report any and all new behaviors to the licensed nurse.

The DNS, UMS and Weekend Supervisor initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10. In-service content included care plans and care plan meetings. Licensed nurses were also educated to document on the 24-Hour Reports, the Resident Progress Notes and on the Behavior Logs and to address on the care plans. The SRNAs were educated to document on the Behavior Logs and report to the licensed nurse. All direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food, and to document on the 24-Hour Reports and to address in care plans. Administrative nurses through direct observations will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Reports and report to the DNS and SW. The DDCO completed in-servicing to all Administrative Staff (ED, DNS, CM, MDSC, Social Worker, UM, RD, Activity Director,

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F 514	Continued From page 65 taken the bread from a resident sitting at the table with him/her. CNA #9 stated she walked over to the resident and removed the bread from his/her hand and from the table. She resumed passing out trays. The staff revealed the next thing they knew CNA #4 shouted Resident #1 was turning blue. The staff stated they immediately called a Code, grabbed a crash cart and lowered the resident to the floor. The licensed staff responded to the code and attempted the Heimlich Maneuver with finger sweeps three times with no success. They stated the resident was not breathing and they could not detect a pulse. EMS was called and Cardiopulmonary Resuscitation (CPR) was started. A review of the EMS report, dated 9/01/10, revealed a Laryngoscope was inserted into the resident's throat and the lodged bread was removed with forceps. The resident's pulse and breathing returned. The resident was sent out to the hospital. Observation of the noon meal, on 09/16/10 at 12:15 PM, revealed Resident #1 was seated at a table with a resident with the same kind of diet. A licensed staff was in the dining room. Staff began passing fluids to the residents. A CNA sat with Resident #1 when his/her glass of fluid was served and stayed with the resident through the resident's tray being served and then fed the resident his/her meal. The remaining staff began passing out the residents' trays. The staff had their backs to the residents in the dining room while passing the trays and the surveyor observed a resident to take and consume another resident's fluids. A review of the comprehensive care plan, for Resident #1 revealed the resident's care plan was	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Reports and Investigative Protocol. The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behavior have been appropriately addressed on the comprehensive care plans. The audits will include but not be limited to: the MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes for the previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the audits will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plans. The DNS will be responsible to report all audit (residents on mechanically altered	

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revised for the resident to sit with residents with the same diet consistency on 09/07/10; however, there were no revisions to the care plan to address adequate supervision/monitoring of the resident due to the behavior of grabbing of food/drinks and the increased risk of the resident choking and there were no interventions to monitor and document the resident's behavior of grabbing food/drinks.

2. A record review revealed Resident #4 was admitted to the facility with diagnoses to include Alzheimer's Disease.

Interviews with RN #2 on 09/16/10 at 5:40 PM, RN #1 on 09/16/10 at 2:40 PM, LPN #1 on 09/16/10 at 5:20 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM and CNA #8 on 09/16/10 at 5:50 PM, revealed Resident #4 grabbed other residents' food/drinks or pulled the tablecloth to pull items within his/her reach. However, further review of the medical record revealed there was no documentation of the resident's behaviors of grabbing food/drinks and pulling the tablecloth to pull items within reach.

Observation of the noon meal on 09/16/10 at 12:15 PM, revealed Resident #4 was seated at a table with a resident with the same kind of diet. A licensed staff was in the dining room. A CNA sat with Resident #4 when his/her tray was served.

A review of the comprehensive care plan for potential for alteration in nutrition/hydration related to mechanically altered diet, end stage Alzheimer's and potential for aspiration, dated 08/04/10, revealed interventions to provide a mechanical soft diet with nectar thick liquids, fed

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine need for additional action steps. If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits will take place on a monthly basis for two months and on an as needed basis thereafter. The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated. The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.

Completion date 9/23/10

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per staff in dining room and encourage to eat slowly. Further review revealed the care plan did not address adequate supervision/monitoring of the resident's behaviors of grabbing food/drinks and pulling the tablecloth to pull items within his/her reach. Additionally, there were no interventions to monitor and document the resident's behavior of grabbing food/drinks.

3. A record review revealed Resident #5 was admitted to the facility with diagnoses of Late Effect Cerebral Vascular Accident (CVA) and Vascular Dementia.

An interview with CNA #5 on 09/16/10 at 5:05 PM, revealed Resident #5 was blind in one eye and saw objects with the other eye and grabbed for them. She stated the resident had grabbed food/drinks belonging to another resident in the dining room. However, further review of the record revealed no documentation of the resident's behavior of grabbing for food/drinks in the dining room.

A review of the comprehensive care plan for alteration in nutrition/hydration related to mechanically altered diet and swallowing problems, dated 03/11/10, revealed an intervention to provide assistance with meals. Further review revealed the care plan did not address adequate supervision/monitoring of the resident's behavior of grabbing food/drinks and there were no interventions to monitor and document the resident's behavior of grabbing food/drinks.

4. A record review revealed Resident #6 was admitted to the facility with diagnoses of Alzheimer's Disease.

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F 514	Continued From page 68 An interview with CNA #7 on 09/16/10 at 5:35 PM, revealed Resident #6 grabbed other residents' food/drinks at times when he/she ate in the dining room. However, further review of the medical record revealed there was no documentation of the resident's behavior of grabbing for food/drinks. A review of the comprehensive care plan for impaired swallowing related to the resident ate too fast causing him/her to choke revealed interventions to provide a pureed diet with regular liquids and to encourage the resident to slow down and take small bites to decrease the risk of choking. Further review revealed the care plan did not address adequate supervision/monitoring of the resident's behavior of grabbing for food/drinks and there were no interventions to monitor and document the resident's behavior of grabbing food/drinks. 5. A record review revealed Resident #7 was admitted to the facility with diagnoses of Mental Disorder. An interview with LPN #1 on 09/16/10 at 5:20 PM, revealed Resident #7 grabbed other residents' food/drinks at times and tried to eat inedible objects. However, further review of the medical record revealed there was no documentation of the resident's behavior of grabbing for food/drinks. A review of the comprehensive care plan for at risk for altered nutrition/hydration related to Alzheimer's and wandering, dated 03/11/10, revealed an intervention to provide a mechanical soft diet with pureed meat and regular liquids.	F 514		

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Further review revealed the care plan did not address adequate supervision/monitoring of the resident's behavior of grabbing for food/drinks and there were no interventions to monitor and document the resident's behavior of grabbing for food/drinks.

An interview with the DON on 09/20/10 at 1:25 PM, revealed during the investigation of Resident #1's incident, she did not identify that there were four other residents (#4, #5, #6 and #7), who also had behaviors of grabbing for other residents' food/drinks. She had not identified that there was no documentation in the residents' medical records identifying the behaviors of grabbing for food/drinks, no care plans to address the behaviors and no interventions to monitor and document the residents' behaviors of grabbing food/drinks.

An acceptable credible allegation of correction for the removal of the Immediate Jeopardy was received on 09/22/10. The Immediate Jeopardy was verified removed on 09/22/10, prior to exit. The alleged date of removal was 09/22/10. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 09/22/10.

The AOC revealed:

Affected residents:

On 09/02/10, the ARNP communicated to all direct care staff, licensed nurses State Registered Nurse Aides, that Resident #1 would be seated in the dining room at a table with other residents who received the same type of mechanically altered diet.

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F 514	Continued From page 70 On 09/07/10, the care plan was updated to reflect dining room seating arrangement for Resident #1. On 09/16/10, the care plan was updated to reflect a problem of At risk for Choking Possible Aspiration related to Dementia with Impulsive Behavior , Past Behavior of Grabbing food and/or liquids, with interventions to include, but not limited to: provide LCS pureed diet with honey thick liquids by small spoon per staff; encourage po intake and po fluids, fed per staff; encourage dining room attendance each meal and sit with resident with same texture diet; supervise all po intake and meal times. On 09/21/10, the care plan was updated, with a problem of no safety awareness as resident grabs out for people and items, with interventions to include, but not limited to: keep resident in supervised area when out of bed; notify nurse of any abnormal behavior; be attentive to resident when reaching; and encourage resident to attend activities. In addition, the Executive Director (ED), Director of Nursing Services (DNS), the District Director of Operations (DO), and the District Director of Clinical Operations, (DDCO), conducted further investigation for Resident #1 on 09/19/10. This investigation consisted of staff interviews and medical record review, to include but not limited to: the comprehensive Minimum Data Set (MDS) Assessment, Resident Assessment Protocols (RAPs), Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes. The 24-hour report, the Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. The SRNA Assignment Sheet and the Dining Room Seating Arrangement Diagram were updated for Resident #1.	F 514		

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The care plan for Resident #4 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing at items on dining room tables, including food, with interventions to include, but not limited to: place at table with residents with same diet; table cloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors.

The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include, but not limited to: sitting at table with others who have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors.

The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but in past, has taken food from others rooms or trays and over eating, with interventions to include, but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow down if eating fast; notify nurse of any new onset of abnormal behaviors and document.

The care plan for Resident #7 was revised on

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F 514	Continued From page 72 09/16/10 with a problem of Socially Inappropriate Behaviors, at time unable to tell the difference from edible and non-edible item, history of taking food off others' trays, with interventions to include, but not limited to: place at table without centerpieces; staff to monitor during meals; will not be seated within reach of other residents' food at meals. Homemade bread would continue to be served during meal service as appropriate and in accordance with MD order for diet consistency. For residents with mechanically altered diets, bread would be altered accordingly and served with the meal service. Effective 09/17/10, residents who have known behaviors of reaching for and obtaining items that are not on their meal tray or that are inedible, have been arranged to be seated at tables with same MD ordered mechanically altered diet. This is reflected on the Dining Room Seating Assignment Chart, effective 09/17/10. Effective 09/02/10, each meal service will be monitored by a licensed nurse for the duration of the meal service. SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse are responsible to conduct observations of all residents during the meal service to identify behaviors or concerns. The licensed nurse are responsible to document any behaviors or identified concerns on the Meal Supervision Log, the 24-hour report and will report the behaviors or identified concerns to the Director of Nursing Services and/or the Social Worker. The DNS and CM will also review the Meal Supervision Logs for the previous 7-day period to validate that	F 514		

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F 514	Continued From page 73 exhibited behaviors and/or concerns are identified and addressed on the care plan and that supervision is appropriate. In addition, the DNS and CM participate in the licensed staff dining room observation to validate appropriate supervision. Effective 09/17/10, each activity with meal service is monitored by the Activities Staff for the duration of the meal service. Activities Staff are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to document any behaviors or identified concerns on the 24-hour Report and to report the behaviors or identified concerns to the DNS and/or Social Worker(SW). Effective 09/17/10, Administrative Licensed Nurses (DNS, Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Minimum Data Set Coordinator (MDSC), Case Manager (CM), Weekend Supervisor (WS) and Staff Development Coordinator (SDC) participate in the licensed staff dining room observation. Administrative nurses through direct observation will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Report and report to the DNS and SW. Meal Supervision, behaviors and/or concerns will be documented at each meal on the Meal Supervision Log. The Meal Supervision Log will be reviewed daily in the Stand-Up meeting and on weekends by the WS to identify any concerns and to validate that appropriate corrective action has been taken. Any concerns identified will be documented on the Meal Supervision Log at the time of the review.	F 514		

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F 514	Continued From page 74 All direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food, and to document on the 24-Hour Report and to address in care plan. Other Facility Residents with the Potential to be Affected: The DNS, UM, Registered Dietician (RD) and Assistant Dietary Services Manager (ADSM) reviewed the medical records of all other facility residents on mechanically altered diets on 09/19/10. Record reviews included, but not limited to, the comprehensive MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs, and Resident Progress Notes. The 24-Hour Report, The Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. Record review was conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The Comprehensive Care Plan, the State Registered Nurse Aide Assignment Sheet and the Dining Room Seating Arrangement Diagram were updated as indicated, based on record review and staff interviews. To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated to document on the 24-Hour Report, the	F 514		

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Resident Progress Notes and on the Behavior Log and to address on the care plan. The SRNAs were educated to document on the Behavior Log and report to the licensed nurse. The DNS and CM will conduct 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan.

The DNS, UM, Minimum Data Set Coordinator (MDSC), Case Manager (CM), and Advanced Register Nurse Practitioner (ARNP) reviewed the medical records of all facility residents on 09/21/10. Record reviews included but were not limited to: the MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes for the previous 30-day period. Record review was conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The comprehensive care plan, SRNA Assignment Sheet and Dining Room Seating Arrangement Diagram were updated, as indicated, based on record review and staff interviews.

In addition, on 09/21/10, all SRNA Assignment Sheets were updated to reflect the intervention for staff to report any and all new behaviors to the licensed nurse.

Systemic Changes to Prevent Reoccurrence of Deficient Practice:

The DNS, UMS and Weekend Supervisor

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initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10. In-service content included Care plans and Care plan Meeting and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff were educated that activity seating groups will be the same as the Dining Room Seating Assignment Chart.

The DO and DDCO initiated Investigative Training in-servicing on 09/18/10 with the ED and DNS. The DDCO completed in-servicing to all Administrative Staff (ED, DNS, CM, MDSC, Social Worker, UM, RD, Activity Director, Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Report and Investigative Protocol.

The DNS and UM initiated additional in-servicing on 09/21/10 with all direct care staff to include licensed nurses, SRNAs, and Activities staff related to meal supervision.

In-servicing was initiated on 09/17/10 and 09/20/10 and will continue until all appropriate staff have attended the appropriate in-service. Staff will not be allowed to work until having attended the appropriate in-service. The in-service will be included in New Employee Orientation for all new hires. The facility does not utilize Agency Staff. If the facility should employ Agency Staff, they will receive the in-service prior to working.

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The ED and DNS will be responsible to validate that staff do not work prior to receiving the in-service. A sign is posted at the time clock to notify staff they are not to work or provide care to any resident prior to reporting to a charge nurse to receive the in-service. If the staff in need of in-service is a charge nurse, they are to report to a charge nurse on a different unit.

Facility Monitoring:

An ad hoc Performance Improvement Committee was held on 09/17/10. Members in attendance included the ED, DNS, UM and RD.

The Medical Director was notified of the Facility Action Plan on 09/20/10.

The ED, DNS, RD and WS will audit residents on mechanically altered diets through staff interviews, direct observations of dining services and through record reviews of Behavior and Mood Logs and Resident Progress Notes. The review will also include the Meal Supervision Log and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audit will validate that all behaviors have been appropriately identified and addressed.

The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behaviors have been appropriately addressed on the comprehensive care plan. The audit will include but will not be limited to: the MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes for the

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previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observation.

In addition, the audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan.

The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine the need for additional action steps.

If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits on a monthly basis for two months, and on an as needed basis thereafter.

The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated.

The Interdisciplinary Team, to include but not limited to: ED, DNS, UM, RD, Social Worker, DM, Activities Director, will review all resident

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events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to validate that the PI process is effective.

The ED is responsible for overall compliance through attendance at the Stand -Up Meeting and by reviewing audits to ensure conducted. The ED will assume overall responsibility for the Performance Improvement Program at the Facility.

The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.

In addition, the DDCO will conduct weekly calls with the facility to review events from the previous week to validate that all events are thoroughly investigated, to include care plan revision.

Interviews conducted on 09/22/10, during the extended survey, with the DON and direct care staff (SW #2, RN #1, RN #3, LPN #2, LPN #6, LPN #7, LPN #8, CNA #3, CNA #5, CNA #6, CNA #11, CNA #13, CNA #14 and CNA #15), revealed there was now a seating chart for the dining room. Residents were seated with

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ROSEWOOD HEALTH CARE CENTER	550 HIGH ST. BOWLING GREEN, KY 42101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 80	F 514		

residents on the same diet consistency. Licensed staff were present in the dining room for all meals and Administrative staff participated in the dining room service. They revealed if any behaviors were noted, the staff reported the behavior to the licensed staff in the dining room. The licensed staff then documented it on the behavior log in the dining room and reported it to the Charge nurse and documented on the 24 hour report and in the resident's record.

Observation of the noon meal on 09/22/10 revealed Resident #1 was seated at a table by him/herself. No food was placed on the table until Resident #1's tray was served. The CNA immediately sat down next to the resident when the tray was served. Residents #4, #5, #6 and #7 were seated with residents with like diets and were seated according to the dining room seating chart. A licensed staff was present during the entire meal. Staff were reporting observations of behaviors to the licensed staff during the meal. A review of the Dining Room behavior observation sheets for 09/22/10, revealed each resident's name was documented with the behaviors that were observed. Observations of Resident #,1 on 09/22/10 at 2:20 PM, revealed the resident was in a wheelchair seated in the area across from the nurse's station in view of staff.

A review of Resident #1's comprehensive care plan revisions, dated 09/07/10, 09/16/10, 09/19/10 and 09/21/10, revealed the care plan had been revised to include interventions to seat the resident at a table with same texture diets, supervise all po intake and meal times, keep the resident in a supervised area when out of bed, notify the nurse of any abnormal behavior and be attentive to the resident when reaching.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING _____ B. WING _____	C 09/22/2010

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ROSEWOOD HEALTH CARE CENTER	550 HIGH ST. BOWLING GREEN, KY 42101

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F 514	Continued From page 81 A review of Residents' #1, #4, #5, #6 and #7 comprehensive care plans, revealed the care plans were updated to include individual interventions to provide supervision for the residents related to their behaviors of grabbing for food/drinks. A review of the in-service trainings provided to all direct care staff, dated 09/17/10, 09/18/10, 09/19/10 and 09/21/10, revealed all staff received training on care plans and care plan meetings, assigned seating charts, dining/meal service supervision, activity seating groups, to report any and all behaviors (to include wandering or reaching for objects to include food/drink) and documentation. In addition, Administrative Staff were in-serviced on 09/20/10, on Documentation, Documenting Residents' Health Status, Needs and Services, and Documenting in a Resident's Medical Record and on the 24- Hour Report. The Executive Director and Director of Nursing received in-servicing on 09/18/10 related to conducting investigations. Although it was determined the Immediate Jeopardy was removed on 09/22/10, non-compliance continued with the scope and severity of a "D", based on the facility's need to monitor for the on-going effectiveness of the corrective actions taken and to ensure evaluation through the facility's Quality Assurance process.	F 514		

Commonwealth of Kentucky
Office of Inspector General
Division of Health Care
Western Enforcement Branch

TYPE "A" CITATION

Facility: Rosewood Health Care Center – SNF/NF
Date: 09/24/10
Administrator: Ms. Kathy Skaggs
Ref: KY# 15337

This citation is issued pursuant to KRS 216.555 and KRS 216.557 and 900 KAR 2:040 for violations of 902 KAR 20:300, Section 8(7)(a). The citation may be appealed according to the provision of 900 KAR 2:020, which states that a written request for a hearing must be made to the secretary of the Cabinet for Health Services within twenty (20) days of receipt of written notice of the action. Any penalty assessed for this citation may be appealed under the same provisions.

Based on the findings of an abbreviated survey concluded on September 22, 2010, the facility failed to provide supervision and monitoring for Resident #1 who had a known history of attempting to obtain food of regular consistency; even though, the resident was able to eat pureed food only.

Resident #1 was admitted to the facility on 12/16/08, with diagnoses including Cerebral Vascular Accident. Review of the resident's medical record revealed during June, 2009, the resident had choked on lasagna, and had been placed on a pureed diet with nectar thick liquids. Review of the resident's care plan revealed no evidence of interventions related to the resident's history of attempting to obtain food of regular consistency.

On 09/01/10, Resident #1 was in the dining room, at a table where bread was served to another resident prior to the meal. Resident #1 was observed, by a Certified Nursing Assistant (CNA), with bread in the resident's hand. The CNA went to the resident and obtained the bread from the resident, and removed the remaining bread from the table. Interviews with CNAs revealed the resident turned "purple" and staff summoned assistance from licensed staff. The Heimlich maneuver was completed, but failed to clear the resident's airway. Staff were unable to detect respirations or a pulse. Emergency Medical Services (EMS) was alerted. EMS arrived and utilized a Laryngoscope and forceps to remove bread from the back of Resident #1's throat. The resident was then sent to the hospital.

Interviews with CNAs and Licensed staff revealed all staff was aware the resident was impulsive around food, and had a history of attempting to obtain food of a regular consistency. However, staff stated they had not reported these resident behaviors to anyone. Interviews with facility staff revealed a care plan had been developed which included an intervention for the resident to receive the meal tray only when staff were able to sit at the table with him/her. Further interview revealed no additional interventions were implemented related to Resident #1's impulsiveness around food, and the repeated attempts to obtain food of a regular consistency.

The above failures of the facility to develop and implement interventions to supervise and monitor residents identified as high risk for choking presented an imminent danger and substantial risk that death or serious physical harm will occur.

ISSUED BY: Brent Lancaster, NV TITLE: NC/I
DATE: 9/24/10

RECEIVED BY: Kathy Skaggs TITLE: Exec. Director
DATE: 09/24/10

DATE TO BE CORRECTED: **September 24, 2010**

CORRECTED: Kathy Skaggs (DATE) 9/22/10

VERIFIED CORRECTED: Brent Lancaster, NV (DATE) 9/24/10